FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0005785

Facility Name: RESTHAVE HOME-WHITESIDE COUNTY

Address: 408 MAPLE AVENUE (Number) MORRISON (City) 61270 (Zip Code)

County: WHITESIDE

Telephone Number: 815-772-4021 **Fax #** 815-772-4583

IDPA ID Number: 36-2464449-001

Date of Initial License for Current Owners: 5/22/69

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501(c)(3)	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact
Name: JAMES HUBER **Telephone Number:** 815-772-4021

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 09/01/04 to 08/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) JAMES HUBER

(Title) ADMINISTRATOR

Paid Preparer

(Signed) compilation report is attached (Date)

(Print Name and Title) KARL APPELQUIST, CPA

(Firm Name & Address) CLIFTON GUNDERSON LLP
P.O. BOX 699 STERLING, IL 61081

(Telephone) 815-625-5800 Fax # 815-626-4386

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5	25	Sheltered Care (SC)	25	9,125	5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	6,799	10,758		17,557	10
11	ICF/DD					11
12	SC		8,005		8,005	12
13	DD 16 OR LESS					13
14	TOTALS	6,799	18,763		25,562	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.64%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location
Date started 04/30/69

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 08/31/05 Fiscal Year: 08/31/05

* All facilities other than governmental must report on the accrual basi

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNT **#** 0005785 **Report Period Beginning:** 09/01/04 **Ending:** 08/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	188,642	18,888	7,523	215,053	(394)	214,659		214,659			1
2	Food Purchase		144,952		144,952		144,952	(7,522)	137,430			2
3	Housekeeping	98,601	16,746	1,691	117,038	(320)	116,718		116,718			3
4	Laundry	53,238	6,656	4,170	64,064	(200)	63,864		63,864			4
5	Heat and Other Utilities			63,503	63,503		63,503		63,503			5
6	Maintenance	52,353	6,468	18,449	77,270	(391)	76,879		76,879			6
7	Other (specify):*											7
8	**TOTAL General Services**	392,834	193,710	95,336	681,880	(1,305)	680,575	(7,522)	673,053			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	848,872	44,716	62,426	956,014	(883)	955,131		955,131			10
10a	Therapy	38,452		2,389	40,841		40,841		40,841			10a
11	Activities	76,752	3,648	9,025	89,425	(516)	88,909	(4,716)	84,193			11
12	Social Services	47,893	372	3,409	51,674	(1,072)	50,602		50,602			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,011,969	48,736	77,249	1,137,954	(2,471)	1,135,483	(4,716)	1,130,767			16
	C. General Administration											
17	Administrative	73,679			73,679		73,679		73,679			17
18	Directors Fees											18
19	Professional Services			13,979	13,979		13,979		13,979			19
20	Dues, Fees, Subscriptions & Promotion			7,586	7,586		7,586	(3,953)	3,633			20
21	Clerical & General Office Expense	60,021	10,073	23,497	93,591		93,591	(8,513)	85,078			21
22	Employee Benefits & Payroll Taxe			278,935	278,935		278,935		278,935			22
23	Inservice Training & Educatior											23
24	Travel and Seminar			1,204	1,204	3,776	4,980		4,980			24
25	Other Admin. Staff Transportatior											25
26	Insurance-Prop.Liab.Malpractice			53,503	53,503		53,503		53,503			26
27	Other (specify):*											27
28	**TOTAL General Administration**	133,700	10,073	378,704	522,477	3,776	526,253	(12,466)	513,787			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,538,503	252,519	551,289	2,342,311		2,342,311	(24,704)	2,317,607			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY #0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			81,962	81,962		81,962		81,962			30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			(92,720)	(92,720)		(92,720)	92,720				36
37	**TOTAL Ownership**			(10,758)	(10,758)		(10,758)	92,720	81,962			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			21,835	21,835		21,835		21,835			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,828	26,828		26,828		26,828			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			48,663	48,663		48,663		48,663			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,538,503	252,519	589,194	2,380,216		2,380,216	68,016	2,448,232			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(7,522)	2		4
5	Telephone, TV & Radio in Resident Room	(4,716)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	92,720	36		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,513)	21		24
25	Fund Raising, Advertising and Promotiona	(2,616)	20		25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,337)	var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 68,016		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 68,016		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

RESTHAVE HOME-WHITESIDE COUNTY

ID# 0005785

Report Period Beginning: 09/01/04

Ending: 08/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IHCA DUES- PORTION FOR LOBBYING	$ (1,337)	20	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,337)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY **#** 0005785 **Report Period Beginning:** 09/01/04 **Ending:** 08/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,522)	0	0	0	0	0	0	0	0	0	0	(7,522)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,522)	0	0	0	0	0	0	0	0	0	0	(7,522)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(4,716)	0	0	0	0	0	0	0	0	0	0	(4,716)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,716)	0	0	0	0	0	0	0	0	0	0	(4,716)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,953)	0	0	0	0	0	0	0	0	0	0	(3,953)	20
21	Clerical & General Office Expenses	(8,513)	0	0	0	0	0	0	0	0	0	0	(8,513)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(12,466)	0	0	0	0	0	0	0	0	0	0	(12,466)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(24,704)	0	0	0	0	0	0	0	0	0	0	(24,704)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 **Report Period Beginning:** 09/01/04 **Ending:** 08/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	92,720	0	0	0	0	0	0	0	0	0	0	92,720	36
37	**TOTAL Ownership**	92,720	0	0	0	0	0	0	0	0	0	0	92,720	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	68,016	0	0	0	0	0	0	0	0	0	0	68,016	45

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organizatior	6 Percent of Ownership	7 Operating Cost of Related Organizatior	8 Difference: Adjustments for Related Organizatior Costs (7 minus 4)	
1	V		N/A	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI**

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNT # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	NONE						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY **#** 0005785 **Report Period Beginning:** 09/01/04 **Ending:** 08/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report

1. Real Estate Tax accrual used on 2004 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000		8
2001		9
2002		10
2003		11
2004		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RESTHAVE HOME-WHITESIDE COUNTY COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0005785

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,787 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [ ] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY LOCATION	354,835	1958 & 1964	$ 10,977	1
2	CREEK STREET PROPERTY	2,500	2003	500	2
3	TOTALS	357,335		$ 11,477	3

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	25			1961	$ 140758	$	30	$	$	$ 140,758	4
5	49			1969	326818		15-33			326,818	5
6											6
7											7
8											8
	Improvement Type**										
9	PATIO COVER			1971	1,500		20			1,500	9
10	LAUNDRY REMODELING			1974	6,242		20			6,242	10
11	GARAGE			1976	2,235		20			2,235	11
12	GARAGE WIRING & DOOR CLOSURE			1980	1,022		10-15			1,022	12
13	FIREPROOF I-BEAM			1981	1,040		10			1,040	13
14	PATIENT REC. ROOM			1982	127,130	4,238	30	4,238		96,763	14
15	CEILINGS			1983	13,650		15			13,650	15
16	PORCH & ACCESS			1984	7,953		10-20			7,953	16
17	SOUTH PORCH, ELEC. DOOR			1984	394		10			394	17
18	CARPETING			1984	1,400		10			1,400	18
19	BASEMENT REPAIR			1985	2,947	100	10-20	100		2,921	19
20	ACTIVATORS/RADIATORS			1986	585		10			585	20
21	HAND RAIL, RAMP, CARPET			1986	1,136		10			1,136	21
22	HEAT CONTROL VALVES			1986	851		10			851	22
23	GAZEBO			1987	1,575		10			1,575	23
24	AIR CONDITIONING			1987	1,048		10			1,048	24
25	REROOFING/PORCH REPAIR			1988	14,500		10			14,500	25
26	DUCTS FOR KITCHEN EQUIPMENT			1989	1,910	96	20	96		1,545	26
27	BRICKS FOR BUILDING			1989	8,500	340	25	340		5,483	27
28	OVERHANG ON BUILDING			1989	3,810		15			3,810	28
29	GENERATOR BUILDING			1992	7,527	501	15	501		6,691	29
30	CARPETING			1993	580		10			580	30
31	ROOF REPAIR			1993	4,840	323	15	323		3,847	31
32	BUILDING ADDITION			1993	203,557	6,429	10-30	6,429		88,389	32
33	CARPETING			1996	352	36	10	36		334	33
34	FOLDING DOORS			1996	2,090	139	15	139		1,310	34
35	SCREEN DOORS			1996	540	36	15	36		333	35
36	FOLDING DOORS			1996	6,688	446	15	446		4,049	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DOORS	1997	$ 828	$ 56	15	$ 56	$	$ 469	37
38	SPRINKLER SYSTEM	1997	8,432	281	30	281		2,389	38
39	FLOORING	1998	991	140	7	140		991	39
40	DOOR ALARM SYSTEM	2001	25,903	2,591	10	2,591		9,932	40
41	SHINGLES	2003	15,500	1,550	10	1,550		3,746	41
42	ROOFING LABOR	2003	15,000	1,500	10	1,500		3,000	42
43	ALARM FOR NEW DOOR	2003	3,420	342	10	342		769	43
44	FINAL ROOF PAYMENT	2003	15,274	1,527	10	1,527		2,673	44
45	DOOR LOCKS	2004	8,234	1,647	5	1,647		1,647	45
46	GARAGE	2004	36,457	1,671	20	1,671		1,671	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,023,217	$ 23,989		$ 23,989	$	$ 766,049	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forwarc		$ 1,023,217	$ 23,989		$ 23,989	$	$ 766,049	1
2	DRIVEWAY	1961	8,794		20			8,794	2
3	DRIVEWAY	1965	2,538		20			2,538	3
4	DRIVEWAY	1969	1,213		20			1,213	4
5	CONCRETE	1970	187		10			187	5
6	BLACKTOP	1975	648		10			648	6
7	ROCK	1976	85		10			85	7
8	FENCE	1977	1,740		10			1,740	8
9	BLACKTOP FRONT DRIVE	1979	11,375		7			11,375	9
10	SEAL DRIVEWAY	1979	1,050		5			1,050	10
11	SEAL DRIVEWAY	1980	5,335		7			5,335	11
12	SEAL DRIVEWAY	1980	660		5			660	12
13	BLACKTOP DRIVEWAY	1982	400		5			400	13
14	TREES & SHRUBBS	1983	466		10			466	14
15	TREES & SHRUBBS	1984	2,081		10			2,081	15
16	ASPHALT & SEAL PARKING LOT	1984	10,950		10			10,950	16
17	SHRUBS & FLOWERS	1985	933		10			933	17
18	FLOWERS AND WOODCHIPS	1986	125		10			125	18
19	SIDEWALK FOR GAZEBO	1987	3,465		10			3,465	19
20	SHRUBS	1988	600		10			600	20
21	SHRUBS	1991	965		10			965	21
22	LANDSCAPING	1993	1,500		10			1,500	22
23	SHRUBBERY	1994	491	46	10	46		491	23
24	SIDEWALK	1994	665	57	10	57		665	24
25	CEMENT	1996	403	40	10	40		374	25
26	FENCE	1996	8,160	816	10	816		7,340	26
27	FENCE	1996	1,148	114	10	114		976	27
28	CONCRETE SIDEWALK	1998	1,760	176	10	176		1,203	28
29	ROCK FOR SIDEWALK	1999	6,884	688	10	688		4,585	29
30	ROCK - FRONT OF BUILDING	1999	1,770	177	10	177		1,092	30
31	LIGHT POLES - PARKING LOT	1999	6,640	664	10	664		4,316	31
32	BLACKTOP	1999	9,075	908	10	908		5,448	32
33	BLACKTOP	1999	2,925	293	10	293		1,734	33
34	TOTAL (lines 1 thru 33)		$ 1,118,248	$ 27,968		$ 27,968	$	$ 849,383	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,118,248	$ 27,968		$ 27,968	$	$ 849,383	1
2	SHRUBBERY	2001	1,443	144	10	144		624	2
3	CANOPY	2001	33,843	3,384	10	3,384		14,664	3
4	CANOPY AND PLANTERS	2001	6,530	653	10	653		2,503	4
5	WINDSOR POLY FENCE	2002	1,319	132	10	132		363	5
6	TREE SHRUBS	2002	335	33	10	33		92	6
7	SIDEWALK FOR N & S EXITS	2003	2,197	220	10	220		532	7
8	SHRUBS	2003	73	7	10	7		15	8
9	DIRT/SAND FOR SIDEWALK	2002	525	52	10	52		150	9
10	RIVER CITY FENCING	2004	1,034	129	8	129		129	10
11	OVERLAY DRIVEWAY	2004	4,114	343	10	343		343	11
12	CONCRETE SIDEWALK	2005	1,870	31	10	31		31	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,171,531	$ 33,096		$ 33,096	$	$ 868,829	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 410,809	$ 45,124	$ 45,124	$	3-20	$ 258,848	71
72	Current Year Purchases	19,370	1,762	1,762		3-20	1,762	72
73	Fully Depreciated Assets	522,160					522,160	73
74								74
75	TOTALS	$ 952,339	$ 46,886	$ 46,886	$		$ 782,770	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	SNOW PLOW	FORD BLAZER	1985	$ 1,450	$	$	$	8	$ 1,450	76
77	MAINTENANCE	4X4 TRUCK	2003	2,000	400	400		5	833	77
78	PATIENT CARE	99 FORD DIAMOND	2004	15,800	1,580	1,580		10	1,580	78
79										79
80	TOTALS			$ 19,250	$ 1,980	$ 1,980	$		$ 3,863	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,154,597	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 81,962	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 81,962	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,655,462	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquirec	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	FILL DIRT FOR FENCE	$ 2,265	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 2,265	$	$	91

G. Construction-in-Progres

	Description	Cost	
92			92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column (

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits
(c) For in-house training programs only. Do not include fringe benefits
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be lis on this schedule.

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY **#** 0005785 **Report Period Beginning:** 09/01/04 **Ending:** 08/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 08/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 52,409	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	119,586		3
4	Supply Inventory (priced at low cost/mrkt)	7,589		4
5	Short-Term Investments			5
6	Prepaid Insurance	12,037		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	615		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 192,236	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,677,211		12
13	Land	11,477		13
14	Buildings, at Historical Cost	1,023,217		14
15	Leasehold Improvements, at Historical Cost	150,580		15
16	Equipment, at Historical Cost	971,589		16
17	Accumulated Depreciation (book methods)	(1,655,462)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,178,612	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,370,848	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 26,825	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,121		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Licensed Bed Fee	6,762		36
37	Other Payroll Deductions W/H	4,547		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 114,255	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 114,255	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,256,593	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,370,848	$	48

***(See instructions.)**

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,182,422	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,182,422	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	74,171	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 74,171	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,256,593	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 2,282,069	1
2	Discounts and Allowances for all Level	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,282,069	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Educatior		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	23,423	13
14	Non-Patient Meals	7,522	14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 30,945	23
	D. Non-Operating Revenue		
24	Contributions	8,414	24
25	Interest and Other Investment Income**	132,959	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 141,373	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,454,387	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	681,880	31
32	Health Care	1,137,954	32
33	General Administratior	522,477	33
	B. Capital Expense		
34	Ownership	(10,758)	34
	C. Ancillary Expense		
35	Special Cost Centers	48,663	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,380,216	40
41	**Income before Income Taxes (line 30 minus line 40)****	74,171	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 74,171	43

*** This must agree with page 4, line 45, column 4.**

**** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,896	2,120	$ 53,855	$ 25.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,058	10,030	184,273	18.37	3
4	Licensed Practical Nurses	9,824	10,831	174,445	16.11	4
5	CNAs & Orderlies	37,788	42,239	417,729	9.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,475	3,491	38,452	11.01	8
9	Activity Director	1,912	2,080	25,026	12.03	9
10	Activity Assistants	5,758	6,267	51,726	8.25	10
11	Social Service Workers	2,873	3,362	47,893	14.25	11
12	Dietician					12
13	Food Service Supervisor	1,808	2,080	30,100	14.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,682	18,197	158,542	8.71	15
16	Dishwashers					16
17	Maintenance Worker	4,133	4,654	52,353	11.25	17
18	Housekeepers	9,305	10,682	98,601	9.23	18
19	Laundry	4,439	5,326	53,238	10.00	19
20	Administrator	1,881	2,160	73,679	34.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,769	4,388	60,021	13.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) LNA	2,222	2,440	18,570	7.61	33
34	TOTAL (lines 1 - 33)	116,823	130,347	$ 1,538,503 *	$ 11.80	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	42	$ 1,890	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	66	2,620	10-3	39
40	Physical Therapy Consultant	37	2,389	10a-3	40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	23	2,025	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	168	$ 8,924		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,513	31,542	10-3	52
53	TOTAL (lines 50 - 52)	1,513	$ 31,542		53

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JAMES HUBER	ADMINISTRATOR	0	$ 73,679
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 73,679

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CLIFTON GUNDERSON LLP	ACCOUNTING	$ 7,950
DUANE MORRIS	LEGAL	6,014
RONALD F. COPLAN	LEGAL	15
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 13,979

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,264
Unemployment Compensation Insurance	
FICA Taxes	123,432
Employee Health Insurance	98,519
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) PLANS	1,960
EMPLOYEE PHYSICALS	760
TOTAL (agree to Schedule V, line 22, col.8)	$ 278,935

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	164
(Indicate # of checks performed 13)	
HPSI DUES	199
IHCA DUES	4,055
IHCA DUES SPENT ON LOBBYING	(1,337)
OTHER ADVERTISING, DUES, SUBSC	3,168
Less: Public Relations Expense	( )
Non-allowable advertising	(2,616)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,633

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MILEAGE REIMBURSE - ERRANDS	542
NURSING/PATIENTS	222
Seminar Expense	
TRAVEL/MEETINGS/CONFERENCES	4,216
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,980

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY # 0005785 Report Period Beginning: 09/01/04 Ending: 08/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number RESTHAVE HOME-WHITESIDE COUNTY **#** 0005785 **Report Period Beginning:** 09/01/04 **Ending:** 08/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union **NO**

(2) Are there any dues to nursing home associations included on the cost repor **YES**
If YES, give association name and amount **Illinois Health Care Association $4,055**

(3) Did the nursing home make political contributions or payments to a politic
action organization? **Yes - Indirectly** If YES, have these cost
been properly adjusted out of the cost report **IHCA - Lobbying**

(4) Does the bed capacity of the building differ from the number of beds licensed at t
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases **YES**
What was the average life used for new equipment added during this perio **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expen
and the location of this expense on Sch. V. **16,176** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedur
consistent with prior reports? **YES** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangement **NO**
If YES, give effective date of lease

(9) Are you presently operating under a sublease agreement YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f
Schedule VII)? YES NO **X** If YES, please indicate name of the facility
IDPH license number of this related party and the date the present owners took ov

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departme
during this cost report period. **26,828**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule
for an individual employee? **NO** If YES, attach an explanation of the allocation

(13) Have costs for all supplies and services which are of the type that can be billed
the Department, in addition to the daily rate, been properly classifie
in the Ancillary Section of Schedule V **YES**

(14) Is a portion of the building used for any function other than long term care services f
the patient census listed on page 2, Section B **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac
a schedule which explains how all related costs were allocated to these functior

(15) Indicate the cost of employee meals that has been reclassified to employee benef
on Schedule V. $ **0** Has any meal income been offset agains
related costs? **YES** Indicate the amount $ **5,925**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **NO**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation f
residents? **NO** If YES, please indicate the amount of income earned from such
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patient **4.5%**
d. Have vehicle usage logs been maintained **YES**
e. Are all vehicles stored at the nursing home during the night and all oth
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjuste
out of the cost report? **no personal use of vehicles**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period $

(17) Has an audit been performed by an independent certified public accounting firm **YES**
Firm Name: **CLIFTON GUNDERSON, LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this co
been attached? **YES** If no, please explain

(18) Have all costs which do not relate to the provision of long term care been adjusted o
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic
performed been attached to this cost report **YES**
Attach invoices and a summary of services for all architect and appraisal fee

SCHEDULE V, LINE 6, COLUMN 3 INCLUDES WASTE REMOVAL COSTS
OF $1,320.00, WHICH IS BROKEN DOWN AS FOLLOWS:

DATE		AMOUNT	PAYEE
10/7/2004	$	120.00	MORING DISPOSAL, INC
11/3/2004		120.00	MORING DISPOSAL INC
1/7/2005		120.00	MORING DISPOSAL INC
2/4/2005		120.00	MORING DISPOSAL INC
3/8/2005		120.00	MORING DISPOSAL INC
3/24/2005		120.00	MORING DISPOSAL INC
5/6/2005		120.00	MORING DISPOSAL INC
6/1/2005		120.00	MORING DISPOSAL INC
6/29/2005		120.00	MORING DISPOSAL INC
8/3/2005		120.00	MORING DISPOSAL INC
8/30/2005		120.00	MORING DISPOSAL INC
	$	1,320.00	

Date	Amount	Employee
09/16/04	22.40	Marcia Blean
11/10/04	87.50	James Huber
11/10/04	14.00	Marcia Blean
12/20/04	12.25	Marcia Blean
12/23/04	14.00	James Huber
01/13/05	17.50	James Huber
01/21/05	17.50	James Huber
03/08/05	28.00	James Huber
03/16/05	17.50	James Huber
04/08/05	12.25	Marcia Blean
04/13/05	51.79	Marcia Blean
04/13/05	17.50	James Huber
04/28/05	17.50	James Huber
04/28/05	14.00	Marcia Blean
04/28/05	10.50	Wendell Strowd
05/16/05	10.50	Marcia Blean
05/16/05	12.25	Marcia Blean
05/18/05	12.25	Marcia Blean
05/25/05	35.00	James Huber
06/08/05	24.50	Marcia Blean
06/13/05	14.00	Marcia Blean
06/22/05	17.50	James Huber
07/13/05	5.95	Scott Wollam
07/13/05	31.50	James Huber
07/15/05	10.50	Marcia Blean
07/22/05	14.00	Marcia Blean

Date	Amount	Employee
10/22/04	85.29	Sara Pessman
11/18/04	7.54	Jan Bos
06/17/05	20.57	Jan Bos
07/22/05	19.01	June Swinson
08/03/05	25.65	Jan Bos
08/08/05	20.01	Jan Baumgardt
08/18/05	44.52	Cassie Hanson

Date	Amount	Employee
09/16/04	28.00	Jan Baumgardt
10/21/04	158.40	Bonnie Bauscher
10/21/04	79.20	Bonnie Bauscher
10/21/04	79.20	Bonnie Bauscher
10/21/04	338.09	Ann Reed
10/21/04	18.85	Marcia Blean
10/21/04	18.85	Marcia Blean
10/21/04	338.10	Ann Reed
10/21/04	74.53	Marcia Blean
10/21/04	74.52	Marcia Blean
10/21/04	103.30	Sonia Dykhuizen
10/21/04	20.00	James Huber
10/21/04	20.00	James Huber
10/21/04	40.00	James Huber
10/21/04	40.00	James Huber
10/21/04	40.00	James Huber
10/21/04	112.00	Sara Pessman
10/21/04	324.90	James Huber
10/21/04	205.90	James Huber
10/22/04	33.60	Lisa Dalton
10/22/04	50.25	Sue Vilmont
11/10/04	74.90	Sue Vilmont
11/18/04	27.22	June Swinson
11/24/04	402.50	James Huber
01/21/05	14.00	Jan Baumgardt
03/02/05	79.80	Sue Vilmont
03/02/05	176.64	Bonnie Bauscher
03/16/05	278.05	James Huber
03/16/05	26.20	Jan Baumgardt
04/08/05	25.50	Jan Baumgardt
04/28/05	68.65	Ann Reed
04/28/05	253.34	Sonia Dykhuizen
05/18/05	140.00	Sara Pessman
05/18/05	81.90	Sue Vilmont
06/29/05	198.80	James Huber
06/29/05	15.05	Sue Vilmont
07/13/05	79.45	Scott Wollam
08/18/05	76.00	Sue Vilmont

Total Travel and Seminar $ 4,980.42

Amount		Amount		Amount	
542.14	Total mileage reimb to employees (errands)	222.59	Total mileage reimb - - for patients (resident shopping,visitations, car rides,other)	4,215.69	Mileage reimb for travel to meetings

LINE 36, SCHEDULE V OF THE COST REPORT INITIALLY REPORTS OTHER CAPITAL EXPENSE OF $(92,720).
THIS AMOUNT REPRESENTS INVESTMENT EXPENSES AND LOSSES/GAINS FOR THE CURRENT FISCAL YEAR AND IS COMPLETELY ADJUSTED OUT ON LINE 10 OF SCHEDULE VI-ADJUSTMENT DETAIL. THEREFORE, ALL INTEREST INCOME OF $132,959 IS INCLUDED ON SCHEDULE XVII-INCOME STATEMENT.

Operating Expenses	Total	Reclassification	Reclassified Total	Description
Dietary	$215,053	$ (394)	$ 214,659	To transfer travel expense from "Dietary - Other" to "Travel and Seminar"
Housekeeping	117,038	(320)	116,718	To transfer travel expense from "Housekeeping - Other" to "Travel and Seminar"
Laundry	64,064	(200)	63,864	To transfer travel expense from "Laundry - Other" to "Travel and Seminar"
Maintenance	77,270	(391)	76,879	To transfer travel expense from "Maintenance - Other" to "Travel and Seminar"
Nursing and Medical Reco	956,014	(883)	955,131	To transfer travel expense from "Nursing & Medical Records - Other" to "Travel and Seminar"
Activities	89,425	(516)	88,909	To transfer travel expense from "Activities - Other" to "Travel and Seminar"
Social Services	51,674	(1,072)	50,602	To transfer travel expense from "Social Services - Other" to "Travel and Seminar"
Travel and Seminar	1,204	3,776	4,980	To transfer travel expenses from the above accounts into the "Travel and Seminar"
		$ -		

RESTHAVE HOME OF WHITESIDE COUNTY DOES NOT TRAIN NURSES' AIDES. THE AIDES ARE RESPONSIBLE FOR HAVING ALL TRAINING COMPLETED PRIOR TO BEING HIRED.